Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Right Honourable Ben Wallace MP
Secretary of State for Defence
Ministry of Defence
Whitehall
London
SW1A 2HB

1 CORONER

I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION and INQUEST

On 22nd January 2020 I commenced an investigation into the tragic death of **Victoria HARRILD-JONES**

The investigation concluded at the end of the inquest on 16th November 2021. The conclusion of the inquest was that:-

Victoria died as the result of a pulmonary embolism (a blood clot in the lung).

Victoria had recently undergone gastric surgery and had subsequently developed peritonitis (an inflammation of the abdominal lining).

Peritonitis is a known complication of her surgery, and this, combined with her underlying health conditions and Victoria's significantly reduced mobility, allowed a deep vein thrombosis to form, which proved fatal when it travelled to her lungs.

At the time of her death Victoria was not prescribed any medication to reduce the chance of a deep vein thrombosis from forming.

The medical cause of death was confirmed as:

1a Right pulmonary artery embolism and right atrium thrombosis

2. Obesity, gastric stomach by-pass surgery (19th December 2019), peritonitis, bilateral hip replacement, immobility

4 CIRCUMSTANCES OF THE DEATH

Victoria Harrild-Jones died on the 27th December 2019 at her home address of [redacted], Sovereign Base Area, Akrotiri, in Cyprus.

A week prior to her death on Thursday 19th December 2019, Victoria had undergone gastric by-pass surgery in Limassol, Cyprus
Victoria was discharged from hospital on Saturday the 21st December 2019, but on the 22nd

December due to the abdominal pain she was suffering, an ambulance was called and a duty paramedic attended.

After an on-call doctor had a conversation with the attending paramedic, Victoria was given pain relief medication, and reported she felt a little better for next few of days.

However, at approximately 06:00 on 27th December 2019, Victoria was sleeping in a chair, she was seen to start convulsing before she stopped breathing.

An ambulance was called but resuscitation attempts, initially by her husband and then military medical personnel were tragically unsuccessful.

Victoria was pronounced deceased at 07:00 hours on 27th December 2019.

A subsequent post-mortem examination identified that Victoria had developed a large blood thrombosis which had travelled to her lungs leading to her death. She had also been suffering from undiagnosed peritonitis at the time of her death.

At the time of her death Victoria had not been prescribed any preventative anti-coagulation medication.

Victoria's underlying medical conditions, resultant lack of mobility and the lack of anti-coagulation medication are, on a balance of probability basis, more likely than not to have contributed to her death.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters given rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you;

the MATTERS OF CONCERN as follows. –

In evidence it was heard that following this incident the Sovereign Base Area medical team have implemented a number of changes to policy and procedures.

However, there is one area of concern which has wider implications which was not addressed.

At the time of her death Victoria had not been prescribed any prophylactic anti-coagulation medication for the period of her recovery at home.

Following her operation on the 19th December 2019 the court was told that whilst in hospital, Victoria was required to wear compression stockings and was given a daily dose of anti-coagulation medication in order to assist in the prevention of a venous thromboembolism from forming.

However, upon Victoria's discharge on the 22nd December 2019 these measure were withdrawn by her treating clinician, the court being told that this is standard practice for all patients in Cyprus.

The court then heard, that for UK based patients, National Institute for Health Care Excellence guidance requires that a prophylactic dose of anti-coagulation medication should be given for a period of at least 2 weeks post-operatively, including periods of recovery spent at home.

As such, anti-coagulation medication would have been prescribed to Victoria post-operatively for at least a two-week period had her operation occurred in the UK.

I am therefore concerned that military personnel (and their dependents) who receive inpatient secondary care from local provider's whilst deployed overseas, may be provided treatment following their discharge which is not compliant with NICE guidance and which falls below the standard expected in the UK.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th January 2022 I, the Senior Coroner, may extend the period if I consider it reasonable to do so.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;-

1. Victoria's next of kin.

I am under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9

Nigel PARSLEY
Senior Coroner for Suffolk
Dated: 17/11/2021